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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>NVN484ASC</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>03/07/2008</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>RENO ENDOSCOPY CENTER</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>880 RYLAND<br/>RENO, NV 89502</b> |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| A 00   | <p><b>INITIAL COMMENTS</b></p> <p>This Statement of Deficiencies was generated as the result of a focused state licensure survey conducted at your facility on 3/7/08.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions, or other claims for relief that may be available to any party under the applicable federal, state, or local laws.</p> <p>The state licensure survey was conducted in accordance with Chapter 449, Surgical Centers for Ambulatory Patients.</p> <p>No deficiencies were identified.</p> | A 00  |  |  |

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE